COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: THERAPY SERVICES TECHNICAL ADVISORY COMMITTEE

March 12, 2019
8:30 A.M.
Public Health Building
Conference Room C
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Beth Ennis
CHAIR

Renea Sageser
Charlie Workman
Linda Derossett
(via telephonic)
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Holly Owens
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Rachel Vowels
Shannon Thornton
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Thomas Brown
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Hilary Armstrong
FOUNDATION HAND &
PHYSICAL THERAPY

Appearing Telephonically:

Pam Marshall
MARSHALL PEDIATRIC THERAPY

Karen Wight
WIGHT SPEECH & LANGUAGE SERVICES

AGENDA

1. Welcome & Introductions

2. OLD BUSINESS
   - Any pre-certification issues currently?

   - Codes - checked the PT list 97112, 97113, 97116, 97124 still listed as episode and these are timed codes. However, other requests have been added, including codes for telehealth

   - Aetna and OT - update? Was information sent to Aetna?

   - Telehealth regulations - Reviewed and PT sent comments

   - Any update on Medicare rules, such as PT/PTA team seeing more than one patient at a time? Confusion on whether KY Medicaid was requiring these rules which would make treatment impossible in many clinics

3. NEW BUSINESS
   - Data request from October and numbers related to therapist/assistant

   - Other New Business from TAC members

4. Public Comment

5. Recommendations to MAC

6. Adjourn

DR. ENNIS: Welcome. We don't have a quorum. Well, is it 50%, Sharley, or is it more than 50?

MS. HUGHES: Fifty-one percent.

DR. ENNIS: So, we have to have four here. Okay. So, we don't have a quorum but let's go ahead and go around the room and see who is here for our note-taker.

(INTRODUCTIONS)

DR. ENNIS: And we do have Linda Derossett on video muted currently because I think she's still in the clinic as well.

Normally, we have been told that was going to count but we don't have a ruling from the AG yet.

MS. HUGHES: And just a little update on that. Teresa Aldridge had sent a request for the Attorney General's Opinion on behalf of the MAC. They declined it saying that they would not offer an Attorney General's Opinion for one member of the MAC.

And, so, I contacted him and I said she is not requesting it on behalf of herself. She's requesting it on behalf of the entire MAC and it was voted on in November for her to do this. And

he still would not - not the Attorney General but the person that had responded to her said the Chair of the MAC will need to do this.

This was a couple of weeks ago. I sent Beth an email on Friday. She still had not sent the request. She was going to try to get it in over the weekend. So, that's what the holdup has been. The Attorney General's Office was not cooperating with me on it.

DR. ENNIS: And if we need to, and we can talk about this at the MAC, too, during our TAC reports, if we need to send a request from each TAC just to show that we're all curious about this and would like to know, we will do that.

MS. HUGHES: I told Beth to be sure she put in the letter, and Teresa had also, all of the Technical Advisory Committees were needing to know this information as well as the Advisory Council for Medical Assistance. So, hopefully we'll get a response from them soon.

DR. ENNIS: Terrific. Appreciate that.

We are in a different room and Sharley is now our contact. I believe you got stuck with all of us, didn't you?

MS. HUGHES: Yes, I did. It's not really stuck. So far, it's not been bad at all.

DR. ENNIS: Like you didn't have enough to do, Sharley. I mean, good heavens. They pulled you back onto the MAC and now you get all of the TACs.

So, I have been sending everything to Sharley and we have our meeting dates for 2019 that we set back in November. We don't plan on changing any of those. So, they will be on the website. If there are any changes, we will email something out, but for now, we're going with those same dates.

Stepping down into Old Business, I know, Charlie, you had some pre-cert issues specific to Aetna, I believe.

MR. WORKMAN: Yes. I do not have any specific cases, however, I do have the concern that's been recurrent.

So, forgive me for the feedback from the phone, but the question was there's a delay in getting fax authorizations from Aetna. And along with that, we are receiving this partial--this says they are partially approved but there's no actual count of visits that are approved.

DR. ENNIS: So, no definition of what partial approval is. Is there a specific contact that we should send this person to?

MS. LUCCHESE: You can send them to me if you have examples so that I can look into them.

DR. ENNIS: These are from constituents in the field forwarding stuff to us. So, can you go ahead and just say your email just so that we have it on the record?

MS. LUCCHESE: Yes. It's l-u-c-c-h-e-s-e-l@aetna.com.

DR. ENNIS: And these were just recent, correct?

MR. WORKMAN: The first one is recurrent. The followup was, especially from Aetna, since they've not used eviCore. That seems to be the delay in the fax authorizations.

DR. ENNIS: So, we worked really hard to get eviCore working right.

MR. WORKMAN: Right, but I'm going to ask this individual to send specific examples and we'll follow up after that.

MS. LUCCHESE: Okay.

DR. ENNIS: I know that we have

had some issues with Aetna previously with kids with OT. I don't have Dale in attendance. Are you guys still seeing that or have we managed to work through that issue?

MS. SAGASER: They were able to help us when we had some issues. So, I haven't heard that we have any.

DR. ENNIS: I know we usually have some constituents on the phone line but we don't have the phone line.

MS. ASHER: I know we worked really hard to address that OT issue. So, I've not from my region seen with kids a lot of issues with the OT portion.

DR. ENNIS: Well, and we didn't get to meet in January. So, I'm just trying to follow up on some things from previous.

MS. ASHER: But, of course, if someone is still having those issues, they can reach out to their rep.

DR. ENNIS: We did want to thank the Cabinet for all of their work on the codes for the fee schedule this year. The majority of things that we asked for were added.

However, we're still having the

recurring issue with several codes being listed as episode codes that should be timed codes. They're on the agenda. Nine seven one one two, 113, 116 and 124 should be 15-minute codes. They're listed as episode codes on the fee schedule for 2019 again, at least on the PT side, I believe also on the OT side and those are ones that we have sent in every year.

So, I don't know who we need to talk to at the Cabinet to make sure that that doesn't happen again next year but we need to fix them this year because if our MCOs are pulling from this fee schedule, that's a problem.

MR. WORKMAN: Do we know who owns the web page for the fee schedule?

MS. RUSSELL: Charles Douglass.

DR. ENNIS: He retired, though.

MS. RUSSELL: No. He's here.

DR. ENNIS: Someone told me in January when our meeting was cancelled and everything got reconfigured that Charles was on his way out the door.

MR. GRAY: He's still here. I was in a meeting with him yesterday.

DR. ENNIS: Good. Then, Charles is the one that we have been sending things

through.

MS. RUSSELL: You might want to call Angie Parker.

MR. GRAY: What are the codes for OT?

DR. ENNIS: The same ones. Those four are listed as episode and they should be timed.

MR. GRAY: I'll take responsibility for getting this to Angie Parker and to Charles Douglass.

DR. ENNIS: Okay. Thank you very much. I appreciate that.

MS. HUGHES: On those codes, 97112, 97113, it says they're listed as episode and they should be timed. It's been corrected?. Okay. Thank you. Bye bye.

MR. GRAY: Was that PT and OT?

MS. HUGHES: Yes. He had sent me the email on them, but since that was Charles I had on the phone, I just asked.

DR. ENNIS: Someone had told me back in January that he was retiring. Is he not retiring?

MS. HUGHES: Now, I've not

heard that. He keeps threatening to retire, and I know he's getting close to being able to retire.

DR. ENNIS: Because I know we were trying to push the codes through because he was on his way out the door.

MS. HUGHES: They were updated on the DMS website on March 6th, so, last Wednesday, I believe.

And the other one down here while I'm just going ahead and giving codes, Charles has--I thought he updated me on that one, too, but he didn't.

DR. ENNIS: The other codes that we've requested back in November when we sent the fee schedule with all the corrections to make sure that it did get put up correctly, they added what we had asked for, to my knowledge.

MS. HUGHES: Okay.

DR. ENNIS: Including the codes for telehealth which is great since that goes into play in July. So, do take a look at those. Do we have a phone number?

MS. HUGHES: Yes. I've got the number and the leader code - 877/746-4263. The leader code 0228488#.

DR. ENNIS: Good morning. Do we have folks on the phone?

MS. MARSHALL: Yes.

DR. ENNIS: We apologize. We did not have our code to get the call started. So, we started the TAC meeting a few minutes ago but I want to get who is on the phone here. So, if you can tell us your name and who you are with.

MS. WIGHT: My name is Karen Wight. I'm with Wight Speech and Language Services in Owensboro.

MS. MARSHALL: And it's Pam Marshall with Marshall Pediatric Therapy.

DR. ENNIS: Thank you all. Anyone else?

The only things that we have covered so far, we received some pre-certification issues with Aetna and giving partial visits but not knowing what partial meant. And, so, we have an email to contact for that and we'll be sending that out.

We did just find out that the codes on the fee schedule that had been previously posted as episode have been changed to timed on both the PT and OT schedule. They also added the

developmental evaluation codes for us, as well as the other codes that we requested and the telehealth codes.

So, we believe that the fee schedule is updated to the way we had requested in November.

MR. WORKMAN: I'm viewing those right now.

DR. ENNIS: Charlie is looking at it; but if constituents in the field see a problem, please send it to us and we can forward it on from there.

MS. MARSHALL: I have a question about that. Has it been approved by the MAC and when do the MCOs get it?

MS. ARMSTRONG: That's my question, too.

DR. ENNIS: As soon as it gets updated on the fee schedule, it gets pushed to the MCOs.

MR. GRAY: The next night.

DR. ENNIS: Yes, within twenty-four hours. So, it should be updated automatically. It doesn't have to get approved by the MAC.

MS. MARSHALL: Okay, because I

know that hasn't happened yet that we're seeing.

MS. ARMSTRONG: We're still seeing codes not paid for by MCOs as well.

MS. SAGASER: Are they going to backdate them?

DR. ENNIS: I don't know if they're going to backdate them or not. That would be a question for the Cabinet. Will they be backdated to January 1?

MS. HUGHES: I'll ask.

DR. ENNIS: Thank you.

MS. ARMSTRONG: Because on the fee schedule, it says effective 1/1/19.

DR. ENNIS: Right. So, they should be.

MS. ARMSTRONG: They should be.

DR. ENNIS: They should be retroactive but that may be something that we just need to resubmit to MCOs.

MS. WIGHT: This is Karen Wight. I have something to add to that, if it's okay.

DR. ENNIS: Go ahead, Karen.

MS. WIGHT: I actually was wondering the true effective date for the 2019 fee

schedule because approximately a month ago, Medicaid was reimbursing in accordance with the 2019 fee schedule and we reached out to our WellCare representative who told us that it takes forty-five days for the new "C" schedule to be loaded by WellCare after it receives it from Medicaid.

So, that seems to be not the case that you were just talking about. I mean, there's a little glitch here.

DR. ENNIS: Let me just restate to make sure that I've got this question correct. I haven't finished my coffee this morning, so, I'm a little behind. Daylight Savings is still kicking me in the rear.

So, the effective date of the fee schedule for fee-for-service is 1/1 because that's what was posted on the site. So, WellCare stated it took forty-five days after that to get it loaded into their system.

Pat is sitting here looking at me nodding. So, I'm going to ask her. Would it then be retroactive to 1/1?

MS. RUSSELL: Yes. Our contracts with our providers allow us forty-five days from the time we're notified by the State to make the

updates in our system. They do go back to the original date that the State defined.

DR. ENNIS: Okay. So, it will take time for the codes to get in the system but they should be billed at the new fee retroactively. Does that make sense, Karen?

MS. WIGHT: Yes.

MS. SAGASER: Can I ask another clarification?

DR. ENNIS: Yes. Go ahead, Renea.

MS. SAGASER: So, do you guys go back and rebill the claims or is it up to the provider to rebill the claims?

MS. RUSSELL: It really depends on what kind of denial you got. Chances are you billed a code that we didn't have loaded and you probably got a no fee. It's actually faster for you to rebill those because it will go straight through as a clean claim.

DR. ENNIS: So, if it's a no-feel denial, go ahead and rebill.

MS. RUSSELL: Yes. And if you got a different denial, reach out to your PR so they can help you.

DR. ENNIS: And if they got paid as an episode versus a timed, then, reach out and have them fix it. Okay. Does that make sense?

MS. ASHER: Once the fee schedules are updated, we generally will do a project and sort of pick up and clean up and make sure everything was paid correctly. And the forty-five days, yes. We have up to forty-five days.

DR. ENNIS: It should take less.

MS. ASHER: And it actually depends on the number of claims, how many claims. We could get done earlier, later. It's the size of the project.

DR. ENNIS: So, Aetna, just for those on the phone, Aetna is saying that they tend to run kind of a check to the system when codes are updated to see what needs to be fixed.

MS. SAGASER: Legally, what do the MCOs have to do? So, should they run a report and fix it?

MS. HUGHES: I'll have to check.

MS. SAGASER: Because it shouldn't be on the provider to have to fix that. It

should be on the MCOs to have to fix these claims if it's an error on their end.

MS. ARMSTRONG: In a timely manner.

MS. SAGASER: In a timely manner.

MS. RUSSELL: But it's not really an error on our end.

MS. SAGASER: But once the State updates the MCOs on this issue and it has to be back-paid, it should be on the MCOs to go back and do----

MS. RUSSELL: We can do that. It just takes a little longer. That's all I'm saying. We can do it either way.

MS. ASHER: Obviously, you would get your reimbursement half that time if you resubmitted the claim.

DR. ENNIS: I'm really hoping that as we continue to move forward and send an updated fee schedule in October or in September prior to the November meeting, that we can head off. I mean, we have fewer incorrect codes this time than we've had in the last five years. It's still a little discouraging that we still had some that were

repetitive, the same ones, but we're getting there. And, so, hopefully, we'll have a good handle on this for next year and we won't have that issue.

The other thing that we touched on and I know we've got a couple of pediatric providers on the phone, so, I'm going to reach out to you guys because we didn't get to meet in January, we were having some issues with Aetna and occupational therapy.

Are we seeing any of that? It seems to be being worked through in most cases but I did want to just kind of ask that question.

MS. MARSHALL: This is Pam. We continue to see denials from Aetna Better Health. Anytime there is a mental health diagnosis, like, a child is having unexplained behavior and maybe they have a mental health diagnosis such as ADD or ADHD or obsessive compulsive disorder, something like that, they will just pick out that phrase and say ADD does not need occupational therapy and just deny it no matter what the report says.

There are denials and we have appealed for situations like this. It's still occurring.

DR. ENNIS: Okay. I've got

them taking notes and they're going to look into that, Pam. I will send you the email of the provider in the room or the contact person in the room and put you guys on an email chain so you can get back to her.

MS. WIGHT: I would like to add something, please.

DR. ENNIS: Yes, ma'am, Karen, go ahead.

MS. WIGHT: In regard to Aetna, we are a speech therapy provider, so, we don't have timed codes. We are a fee for episode.

We have repeated partial denials from Aetna. Actually, the number of visits that they allow is significantly reduced compared to the other MCOs in the state and this is a consistent feature that has been used by Aetna.

And, so, we're trying to understand how that MCO can function so differently than the other MCOs in the state.

DR. ENNIS: I think right now - and this is just a guess on my part - Aetna is one of the few that's not using a third-party administrator for pre-cert. They're doing it themselves.

We've managed to work through

some of the other TPA's with some of the issues. So, it may just be we need to work with whoever is doing the authorization to talk about how they're determining medical necessity and all of those things.

Is there a way to put either some members of this TAC or a constituent group together with that person just to talk through or what would be the best way to handle that with you guys?

MS. ASHER: Was that Karen?

DR. ENNIS: That was Karen.

MS. ASHER: Okay. Yes.

DR. ENNIS: We've had members of this TAC sit down with several - and I've been on phone calls with eviCore for like all my life at this point - just to talk through especially with the pediatric situation because it is very different than your adult musculoskeletal population. It's the same thing with your adults with any medical complexity. Those kinds of things are just a little different than ACL repair, total knee.

So, we would be happy to try and meet with whoever does the prior auth with Aetna just to talk through.

MS. ASHER: Yes. I know you have Lisa's contact, if you want to set something up and I can join.

DR. ENNIS: Okay. Great. That sounds great.

MS. MARSHALL: Beth, this is Pam. Is Dale in the room?

DR. ENNIS: He is not and he is not online either.

MS. MARSHALL: Dale and I and some other OT's in the state, we sat down and met with Aetna twice and met with the Medical Director who was new at that time and that meeting wasn't all that productive because he was new and wasn't understanding the situation, but, then, we had a phone meeting with the pediatricians that are reviewers.

We thought we were able to educate them some but everything has slowly moved back to where it was prior to that meeting because that meeting wasn't as productive as we had hoped.

So, I'm wondering how we need to go about this differently this time to bring better understanding.

DR. ENNIS: We'll get a couple

of us from the TAC and try to sit down with them. We'll try to get either one from each discipline or at least two of us and see where we can go and hopefully come with a different outcome now that the Medical Director has been there a while and see where we go because I remember that meeting was like mid-year last year, correct?

MS. MARSHALL: Correct.

DR. ENNIS: Okay. Thank you, Pam.

MS. WIGHT: This is Karen. I have a quick followup on that. When you do that, please be sure there is a speech therapy interest, not just OT and PT.

DR. ENNIS: Absolutely. Yes, ma'am. No. Renea is sitting right here at the table and I have a feeling that she and I will probably be at least two of the three.

MS. WIGHT: Thank you.

DR. ENNIS: You're welcome.

MS. SAGASER: I can get with you, too, Karen.

MS. WIGHT: Okay. That would be great.

DR. ENNIS: I did put the

telehealth regs on here just because we had been talking about them being released back in November and they did release some draft regulations for the Medicaid side of telehealth. They were sent to all three organizations for comment. I know KPTA did send some comments. I think KSHA did as well.

MS. SAGASER: I sent them back to our lobbyist and, then, I think I sent them back to you as well. So, I don't know if I was supposed to send them to anybody else.

DR. ENNIS: I know ours got forwarded. The only concern that I think the organizations had with the regs was there was a drop-off in reimbursement that is not allowed in the law.

So, that was our biggest area of concern was after the first year or two, it was going to be reimbursed at 85% instead of 100% and the bill that was passed specifically says it has to be paid at the same amount as face-to-face.

So, those were our comments that we sent in. We'll wait to hear if there's any feedback on those. I think any meeting that might happen related to that would be scheduled at the end of the month but I don't know that anything has been scheduled, the public comment.

MS. HUGHES: The public comment? I'm not real sure when that will be.

DR. ENNIS: I would assume they're probably waiting until after the Session ends because it's a little chaotic.

MS. HUGHES: By statute, it has to be within a certain time frame of when the reg was filed but I'm not real sure when the reg was filed. David, do you know when the public comment hearings are going to be held?

MR. GRAY: I do not.

MS. HUGHES: I know they're going to be held here.

DR. ENNIS: I want to say when we got the regs, when you sent them out, end of March is something that's ringing a bell in my head with what was stated at the end of them.

MS. HUGHES: Let me see if I can find it. Just as an FYI. The fee schedule change backdates to January 1 and the MCOs are being notified today of the changes. So, I got that update. I'm still waiting on one thing from somebody else.

DR. ENNIS: Okay. Terrific. So, we'll wait and hear if there is a public hearing

scheduled. We'll at least go listen, if not just kind of support the comments that were sent in.

There was a little different wording than what has been in national telehealth regulations, so, we did make a comment on that but I don't know that it was anything huge. It's just the definition of face-to-face not being included as a component but we're happy to provide the comments that we sent in to anybody if they want them.

We had a question in November and we got kind of nebulous answers and, then, we weren't able to meet in January.

One of the questions that had come up was is Kentucky Medicaid applying the Medicare rules to patient care situations?

So, does it have to be one patient at a time, especially if you have a therapist assistant team who are bouncing back and forth between two? That would preclude efficiency of treatment and care, and we never really got good answers.

MR. WORKMAN: I think one of the clarifications may be that the AMA establishes CPT codes that are on the premise that it's a one-on-one therapy intervention service. So, it's not

really a Medicare requirement. It's an AMA CPT guideline.

So, I think rewording that statement to say potentially can CPT codes be billed simultaneously?

DR. ENNIS: And I think the question came up from constituents because CMS oversees both programs, Medicare and Medicaid, but the same guidelines don't apply to both programs.

And, so, Medicaid does not have to use Medicare rules of how many patients you can see and all of those kinds of things.

MR. WORKMAN: It's just that Medicare did not set that rule, the Centers for Medicare.

DR. ENNIS: Correct. And, so, there was a question as to whether Kentucky Medicaid was applying those rules because that's going to impact access to care pretty tremendously in most of our clinics.

And we have some practices across the state that are fairly big providers that are getting legal advice not to take Medicaid because they can't provide under those circumstances, and, so, we were trying to get a clarification regarding

that.

MR. GRAY: I'll follow up with Angie on that.

DR. ENNIS: That would be great.

MS. HUGHES: I've got a little bit of a thing here from Stephanie is that you all, of course, need to follow coding guidelines and our regulation is currently under review right now for any changes.

DR. ENNIS: And what we had sent to Stephanie was most third-party insurers in the regular market allow you to treat more than one patient at a time if you're a team and you're providing individual care to each patient. That's not a problem.

And, so, they were looking at applying that to Medicaid as well with people using the group code appropriately if they're treating multiple patients at the same time using the same activities under the same, you know, but we haven't gotten anything back.

So, we're just trying to clarify those things because we do have some anxious providers out there that don't want to get----

MS. MARSHALL: Beth, this is Pam. I just sent this question to Jessica Jackson. I think the way I understand it is we're asking if the CMS eight-minute rule or the AMA eight-minute rule that used to be called SPM, I think, prior to I think it was 2000 maybe when the CMS eight-minute rule came into place.

DR. ENNIS: Correct.

MS. MARSHALL: But I've got a really good description I can send to you, Beth, that describes the difference between the two.

DR. ENNIS: That would be great.

MS. MARSHALL: But I think my understanding is that federal payors follow the CMS eight-minute rule. I'm not sure if we do or not - that was my question - versus the AMA eight-minute rule because the AMA eight-minute rule, the example of that would be if you only saw a patient for less than eight minutes, like, seven minutes of a code, you could not bill it.

DR. ENNIS: Correct.

MS. MARSHALL: But you can - the CMS eight-minute rule is your total time. If your total time was twenty-four minutes, you could

bill those two units. It's a different way of calculating and calculating the mixed remainders at the end.

So, I think it is important for us to figure out which way and, then, what do the MCOs follow, if we have to get that from each of them. And it's harder for an individual provider to get that answer. It probably would be easier for the TAC to get that answer from all five.

DR. ENNIS: And that's what we're trying to do. So, if you could send that to me, Pam, that would be great. I can forward it on. I think that might add some clarity.

MS. MARSHALL: Yes, I will.

DR. ENNIS: Thank you.

MS. HUGHES: And just as an update. The public comment meeting was held on February 25th.

DR. ENNIS: I knew it was at the end of the month somewhere but I think we had until the end of this week to send comments in. Ours went in mid-February, I think.

Okay. Anything else that got left off Old Business?

MS. HUGHES: If I can, because

I know we haven't talked about the guideline letter that the Commissioner sent out. And one of the main things that she wants coming from these TACs is to-- well, a couple of things, is to not use the TACs for specific claims issues like what we have kind of been doing today.

We've got the MCOs here. If you all want to meet with the MCOs after your meeting, we can save the room. You all can do it but the TAC forum is not the actual forum that should be used for this type of comments. If you want to beat the MCOs up in a meeting off the record, Terri and I would leave and you all can beat them up. Just don't beat them up bad because, remember, they still have to pay your claims.

But what she wants from you all is recommendations going forth from all the therapy providers - speech, OT and physical therapy - of how the Medicaid Program can do better to serve and improve the lives of our members.

So, she wants to kind of get away from claims issues in this meeting and producing something, ideas. Like, at the Home Health TAC, they came up and said something about they had in-home monitoring that they can do.

DR. ENNIS: Yes, part of telehealth.

MS. HUGHES: Well, it's not telehealth. It's telemonitoring. They tell me it's not actual telehealth.

DR. ENNIS: It's a component but it's a separate piece.

MS. HUGHES: But it's something that they can monitor the patient every day to determine how they're doing and this and that and get with them and see them more than just like once a week or once every two weeks and there's been studies in a couple of states as to how it helps cuts down on readmissions to the hospital and that type of stuff.

And, so, it's that type of stuff of what we can do with the therapy services to better improve the lives of our beneficiaries.

So, if we can kind of start kind of----

DR. ENNIS: And what we have discussed because I'm on the committee with Dr. Partin after that letter came out - the MAC formed a committee - and one of the main concerns that came out of that letter was when we talk about claims issues in these meetings, it's usually not just one

person. It's usually a multiple-person issue because if it comes to us in an email and it's a one-person issue, we give an email directly to an MCO, but if it's seven different providers, then, we're going to bring it here and try to facilitate so that it doesn't end up at the MAC, and that seems like a really legitimate use of the TAC's time.

We also come up with things like we got our data that says that less than one percent of what's billed for therapy is being billed using that assistant modifier.

And, so, if we want to provide services and have good access for our clients, we need to get rid of that differential so people can provide care and keep the lights on.

So, the committee is still working through some of the response to the Commissioner, but I think there's a lot of concern about some of the things that she's asked for.

MS. HUGHES: I know there's concern from you all, but, by the same token, just like these claims issues that you all are having, the MCOs nor us can provide you with any answers because, number one, we don't come here with computers that we can go in on the system and look up and see what's

going on.

DR. ENNIS: Right.

MS. HUGHES: And to provide us with a general of saying, okay, Aetna is providing partial authorizations and not giving us the number of visits and this and that, without us having some examples of cases which can't be given to us in an open forum, and, plus the fact that if tomorrow you all go back to your offices and you start having issues, you've got a two-month waiting period that you have to wait before you come back for another TAC instead of going ahead and----

DR. ENNIS: But if it just comes to my office, I'm going to call them. If I have seven providers coming to me saying this is an ongoing issue and we've already contacted them and we've worked through it, this gives us a way to set up that meeting with their pre-cert people. We don't expect an answer at this meeting.

MS. HUGHES: Right.

DR. ENNIS: We never have in five years.

MS. HUGHES: But by the same token, if you're having - and I'm not----

DR. ENNIS: I know. You're in

the middle, Sharley. I get it.

MS. HUGHES: Well, I'm in the middle. What I'm getting ready to say is my personal opinion. This is Sharley saying this. I'm not speaking on behalf of the Commissioner or Medicaid.

Seven providers having an issue out of however many providers of physical, OT and speech there are, it's a huge issue for each of those seven individual providers but it may not be something that is trending. It may just be something that those seven providers are seeing.

DR. ENNIS: Actually, it probably is because most of our providers are multi clinics. So, like the ports of the world, Renea's company has how many different locations?

MS. SAGASER: Fifty-three.

DR. ENNIS: Fifty-three. So, if we're getting comments from those larger groups, it's a problem.

MS. ARMSTRONG: And a lot of providers' offices, I mean, we've been in practice for five years and we just found out last year that these meetings even happened. So, I think that providers might not know exactly where to take their questions as well.

MS. HUGHES: Well, we're going to be putting together a contact list to send out to you all as to who to contact for each of the MCOs and for DMS. The statute specifically says you all are an advisory committee, and as an advisory committee, that doesn't really mean coming here and discussing claims issues that you're experiencing either with fee-for-service or with any particular MCO.

MS. SAGESER: I was going to say, I sort of agree with you on that and I do like your idea of allowing us to use the end of the meeting to discuss that. And if after that meeting we determine that that is a huge issue, can we put it, then, on the--does that make sense?

MS. HUGHES: At that point, after you've met one-on-one with the MCOs, if you can't get resolution, then, what we want you to do - now, you've got the ability to file an appeal. You've got the ability to file through Medicaid and there's a complaint form out on Medicaid's website that you can use.

But if we were doing this today, if you met with an MCO at the end of the meetings and they still did not give you a resolution, then, who you should contact with that is

Angie Parker and say, Angie, Aetna is driving us up a wall - and it could be any of you. It's just Aetna is at the beginning of the list and we do them alphabetically.

MS. SAGASER: I do think that the TAC, though, should reserve time at the end to allow our providers, especially on the phone who are calling in, to have that time to discuss their problems.

So, I think as long as we're able to address these problems, we can do both. Does that make sense?

MS. HUGHES: Right. And we've offered that to every one of the TACs. So, this is our first time since the guideline letter went out of meeting with you all.

So, we have the room until ten and I know you said your meeting normally lasts for about an hour. So, more than likely because so far what we've done for the last thirty minutes has been claims issues, and, so, we could use that at the end and then let you all concentrate with Medicaid staff and stuff in the room with you on ways that we can improve the lives of our members and then have your meetings individually with the MCOs.

We are not trying to take away your ability to----

DR. ENNIS: No. I get that and I think part of the challenge has been that therapy has only been a covered service for the last five years. So, we haven't been a part of this whole system. Twenty fourteen was when we first started getting paid.

MS. HUGHES: Well, it was covered only on inpatient or to the hospital.

DR. ENNIS: Right, or dual eligibles. Those were the only others.

And, so, right now, I mean, our ability to serve the clientele is our biggest concern and keep the lights on. If we can ever get through that and we've been trying to do some other things like the assistant differential is keeping people out of business and it's affecting access, especially in rural parts of the state.

MS. HUGHES: Are you talking about the physical therapy assistants?

DR. ENNIS: Yes. It's PTA, OTA and there was also one with the CFY.

MS. SAGASER: I did get notice from Stephanie that----

DR. ENNIS: That they fixed the CFY?

MS. SAGASER: ----the terminology was going to be fixed in March. Do you know if that has been fixed?

MS. HUGHES: I do not know that.

DR. ENNIS: And that was just specifically for CFY, right?

MS. SAGASER: I did hear that CFY was coming out in March but I don't know if that was the others. And, so, I was wanting to verify that was fixed.

MR. WORKMAN: When MCOs began, this was often used as a bit of an accountability to try to standardize processes, systems so that services are predictable and it benefits the payors.

So, there was so much variation in handling any type of benefits in general for therapy services that standardizing process was predictable and beneficial to all clients throughout the state.

I receive feedback from folks in the Greater Lexington area when they're trending after they have been addressed. And, so, that's why

I bring it, especially a partial payment component. Once it has been addressed, I always respond back to say have you addressed this directly because I can't bring examples here, but it helps because these folks in today's particular example, we now can offer them a more direct contact to resolve it quickly for the benefit of the person needing care.

If we go through was it Angie, then, we're months out of resolving an issue for our beneficiary and that's where I think there's opportunity to tap into that.

Now, we can do it at the end which is just fine but I think it's important to look towards standardizing work flow operations so that it's more predictable and it benefits our readily, knowledgeable not just providers but those receiving that care.

DR. ENNIS: And I think we have been very effective in five years at not taking little things to the MAC. We have been pretty good about just bringing the big issues.

MS. HUGHES: And I understand five years ago, you all were brand new coming in as independent therapists and so forth being covered.

If you're coming to Angie and

it's still taking you all a couple of months to get issues resolved, then, we need to know about those.

DR. ENNIS: And it's not just Angie. It's been anything that we've taken to the Cabinet over the last five years has taken six months.

MR. WORKMAN: And the fee schedule is a great example. That was an issue for two or three years. That should be something that's wrapped up within a couple of months' time frame.

And what happens is even if it partially corrected, which it was in 2017, when they reloaded 2018, they defaulted back to the old form, right? So, those trends are opportunities.

MS. HUGHES: When you see something like that that the Cabinet has done, then, yes, by all means, let us know that because if we defaulted back to that old fee schedule, we need to address that.

MR. GRAY: That's very TAC appropriate.

DR. ENNIS: That was at last June's meeting or May's meeting, we said, okay, so, now we're going to start bringing full fee schedules to the September meeting to give to the Cabinet to

compare to the one they're uploading to make sure and it's still uploaded wrong.

MR. WORKMAN: That actually came from a discussion of claims not being appropriately reimbursed. So, it came out of those individual components.

MS. HUGHES: Technically, and I only know this because I've been hearing them tell the MCOs for years is they should rely on our fee schedule and the regs; but as far as really the fee schedules, unless we're adding a new code, they really should already have those. They're separate from ours. Each one has their own.

But I still think we can accomplish what you all are wanting as far as working straight with the MCOs.

I used to work for an insurance carrier. I'm not going to tell which one it was. I was there for twenty-one years and I would like to think that if you get a hold of these folks or your Provider rep, they would hopefully take care of the issue. And if it is an ongoing issue with multiple providers, hopefully they would take care of it.

I know that sometimes doesn't happen because it didn't happen with the company that

I worked with, but if you send me an email and just say I'm getting a lot of issues from ABC MCO - I'm not going to pick on any of them this time - then, if you can provide me with examples, I can send those to Angie. She can work with said MCO and say, look we're seeing it also. Here's all these examples. Fix it.

And, so, hopefully, we can get it to the point where the time that you all have to spend arguing and fussing at the MCOs - and I don't think you really argue and fuss at them.

DR. ENNIS: I was going to say. Honestly----

MS. HUGHES: I think it's conversations that you have with them. They're good guys and ladies.

DR. ENNIS: I'd like to think that this one has not operated that way and that we've been able to not spend a lot of time but just kind of facilitate things that have not been worked out and have been brought to us.

MS. HUGHES: And if you think that your meetings that you need to have an hour and a half with DMS and talk about this type of stuff, then, we can schedule the room for another hour after

the meeting for you all to have with the MCOs and can hash through all of your issues.

MS. MARSHALL: Beth, to add something. This is Pam again. Just speaking on behalf of other independent providers that work with all five MCOs, at any one given time, we have one or two projects and problems going on.

And the complaint process I'm very familiar with - we use it - however, the Cabinet has reduced that down, I believe, to only one liaison. It used to be five, one for each MCO, and things just don't get resolved.

I'm just going to tell you my experience. We had a credentialing problem where providers were turned in on 6/1 of '18, and we just got those providers loaded a month ago, and we went through the complaint process. We went through everything we were supposed to go through.

It's not working great right now when there's one person trying to handle all of those complaints that are coming through.

MS. HUGHES: Pam, let me give all of you an email address for a DMS staff member. Corey Kennedy. Let me get her email up here because if I just say it's Corey, it's going to be CoreyE.

It appears to just be corey.kennedy@ky.gov. And Angie is Angelaw.parker@ky.gov.

And if you are having some problems. I wasn't aware that they reduced it to one liaison. So, I'll ask.

MS. ARMSTRONG: I can speak to exactly what she is saying, too. That's happening in our clinic as well.

MS. HUGHES: And, so, you use those same folks. If you're having problems with somebody because Angie is the Director over the MCO Division and Corey is the one who is over - I can never remember which branch it is - but she oversees the liaisons and so forth that we have.

So, if you all are having issues with getting responses back or getting them to help you resolve something, go to Corey and Angela. Angela is newer. She has been there a while now, but from what I have seen with Angie, she gets the job done. And everything where I have worked with Corey on, she has been very quick and responsive in getting answers back.

So, if you all are getting some issues from DMS; and if that doesn't get it, contact me and I will go to the Commissioner with it.

DR. ENNIS: I think our biggest challenge is just making sure that folks have access and not being able to have providers credentialed and not being able to get paid appropriately and keep the lights on is impacting access. And we can't even look at how do we make improvements in access until we get them in the door in the first place.

MS. HUGHES: Now, when you're talking provider credentialing, is it the MCOs you're having issues with or DMS?

DR. ENNIS: I think it's both.

MR. GRAY: I think it's an enrollment issue. It's a Medicaid enrollment issue. You can't credential until they can get them enrolled.

DR. ENNIS: With the MCOs until. And I don't know how the new portal is working. Has anybody been part of that pilot?

MS. WIGHT: It's wonderful. It's wonderful.

DR. ENNIS: I mean, every now and then, we get good news, too.

MS. WIGHT: I feel like a miracle has just occurred.

DR. ENNIS: Okay. So, the

clouds have parted and the sun is shining.

MS. MARSHALL: I'm not hearing the credentialing problems. It's the MCOs. We'll submit to them and things will just get dropped sometimes along the way. There are some that are good and some just drop it internally.

DR. ENNIS: But that initial new provider portal for DMS is working well?

MS. MARSHALL: Wonderful. Wonderful.

DR. GRAY: There is a piece of legislation - and I can't remember the number on it - that's clarifying House Bill 69 that's passed both the Senate and the House, on the way to the Governor. I can't imagine he won't sign that bill. The Hospital Association was pretty strong behind it.

I'm kind of the backstop, I guess, when all else fails, when all systems don't work. That's what I do. And, so, I'm davidl.gray@ky.gov. When all other systems fail, that's kind of where I come in.

MS. HUGHES: And Carl Ishmael, and it is just carl.ishmael.@ky.gov. and he's the Director over Program Integrity which handles provider enrollment. And, so, if you're having some

issues.

The statute gives us ninety days. It's amazing how many because we not only have new providers but providers recertifying, and, so, they have a huge volume of stuff coming in, but Carl is usually pretty good about responding also. A lot of times he's out doing work but he also checks his email when he's out.

DR. ENNIS: I did send out to the TAC members the data request response. We had submitted a data request back in October. It got lost in the shuffle. So, I finally got it from Stephanie I believe a couple of weeks after our last meeting was cancelled, so, the end of January.

And it's from the first six months of last year. I will be submitting this month for the last six months of last year to look at the different types of services that are being billed but mainly to support our request to get rid of that modifier, that assistant modifier.

What we got back was that out of the one million a hundred and ten codes that were billed last year, only seven thousand of them were billed using the modifier.

So, there really is not a

significant use of that modifier. It's not going to impact costs dramatically to get rid of it and I think it will improve access to care. If we get another six months that looks like that, I think we've got an even more solid leg to stand on but we'll be passing that on, and I know that the Cabinet was looking at that as well.

MS. HUGHES: Stephanie did give me an update on that that said due to upcoming regulation changes, I'm not sure this data pull is relevant. So, I'm not aware of that the regulation changes are.

DR. ENNIS: I'm not either. It's for the CFY.

MS. SAGASER: But it may be the others, too.

DR. ENNIS: They would never give us a definite on the others.

MS. SAGASER: I know but that's why I think she might have said it that way. Maybe that's a positive.

MR. WORKMAN: What's the update on the CFY?

DR. ENNIS: They're going to be billed under the--they're not going to have to have a

provider number. They're be billed under their supervisor's ID.

MS. SAGASER: Which is the way it's supposed to be.

DR. ENNIS: It's the way it's supposed to be. And that was the discussion for the KOTA and the PTA as well is not having a separate provider number for those assistants but having them bill under their therapists, under a supervisor's number, but it looked like it was heading that way and then it didn't go anywhere. So, we've had a six-month stall.

MS. SAGASER: When do those regulations come out?

MS. HUGHES: She didn't tell me that.

MS. SAGASER: Because she said mid-March to me. So, that way, then, we could have that by the next meeting.

DR. ENNIS: Okay. Well, the next MAC meeting is at the end of the month. So, I will see here there and I can ask her.

MS. SAGASER: And maybe they came out by then.

DR. ENNIS: Anything else,

Renea, Charlie? Linda, I know you are muted but I'll unmute it if you've got something to say. Anything else? I know you shared some of the stuff that was received but was there anything else that came across?

MR. WORKMAN: No other issues but we' try to frame it in the scope of regulations for improvement.

MS. DEROSSETT: This is Linda. I did not get unmuted, so, I ended up calling in.

DR. ENNIS: Oh, good. Hi. I apologize. That might have been my fault. Have you heard anything from your side of the state, Linda?

MS. DEROSSETT: No, not really. I just kind of am with you all on some of the commenting a while ago. I think that we have to work through these issues to be able to provide the care and increase the benefits for the beneficiaries.

DR. ENNIS: And I get that we don't want to take up Cabinet staff time, too. I understand that completely.

DR. DEROSSETT: I understand that, too, and we can do that at the end and maybe I can come down there for some of the meetings, too.

DR. ENNIS: Well, I'm hoping

that we will get a ruling soon that will let us continue to use video because it's ridiculous to me for health care providers to drive three hours across the state for a 45-minute meeting to an hour meeting when they could be providing care in their location. That just makes no sense.

MS. DEROSSETT: It is difficult from this area.

DR. ENNIS: Absolutely. And Dale is in Owensboro and Renea has got to go to Indiana today. I drove up from Louisville.

We can't make any recommendations to the MAC on anything because we don't have a quorum.

Our next meeting is scheduled for May. It's May 14th at 8:30.

MS. HUGHES: And especially for those on the line, depending on who had the TAC was the call-in number that was used. We're changing them all to my call-in number. Those will be posted on the web. And for those that are on the phone today, I think it's the same phone number - 877-746-4263. The participant code will be 2927471 and that will be posted on the website hopefully this week.

DR. ENNIS: Anything else?

MS. WIGHT: This is Karen. I have something. This is in regard to PA requests sent to Medicaid. For a long time we submitted those via fax, but then there was some type of problem and they needed to be emailed as an attachment. Has this been resolved yet so that they can be faxed in again? It's a little time-consuming.

DR. ENNIS: We can find out and I'll email you, Karen.

MS. HUGHES: Was that just to Medicaid?

DR. ENNIS: Just to DMS.

MS. HUGHES: And that was for PA's?

DR. ENNIS: For prior auth.

MS. SAGASER: How are they sending those HIPAA compliant?

DR. ENNIS: Were you using encrypted email?

MS. WIGHT: I don't know. I'll have to check with my office manager. All I know is that we had faxed those in forever and, then, several months back, we were informed that they would need to be emailed as an attachment. There was some type of problem with the system. And, so, we have continued

to email them, however, it is much easier and time efficient to fax those in.

DR. ENNIS: Well, if we're emailing those, that should be an encrypted email.

MS. WIGHT: I'm sure at the desk. I'd have to check to make sure she is doing that.

DR. ENNIS: We will check in and get a response from our prior auth folks from DMS and I'll email it out.

MS. HUGHES: I'm emailing them right now to ask.

MS. SAGASER: DMS should ask for it to be sent via email----

DR. ENNIS: If they don't provide an encrypted method to do it because that's a HIPAA issue.

MS. SAGASER: I know Passport has that portal.

DR. ENNIS: You can upload it to a portal. Thank you, Karen. We'll get back to you.

Anything else? I will provide any follow-up from the MAC at the end of the month and then we'll be here in May. Thank you.

MEETING ADJOURNED